Issues in Aging

LECTURES AND DISCUSSIONS . . . . . .

NOVEMBER 1976 - JUNE 1977

A REPORT ON THE COMMUNITY EDUCATION FORUM SERIES SPONSORED BY THE METROPOLITAN COMMISSION ON AGING IN COOPERATION WITH UNIVERSITY COLLEGE OF SYRACUSE UNIVERSITY, SUPPORTED BY A TITLE IV TRAINING GRANT UNDER THE OLDER AMERICANS ACT, FUNDED THROUGH THE NEW YORK STATE OFFICE FOR THE AGING.

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Copies of this report are available from Metropolitan Commission on Aging for participants in the program and providers of elderly services in our community. Persons interested in receiving this report may contact MCOA. If there are no additional copies, the booklet may be made available for duplication.

Further use or publication of this series should include a recognition of the origin of the material:

'76-77 Issues in Aging Series
sponsored by Metropolitan Commission on Aging
421 Montgomery Street
Syracuse, New York 13202

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A WORD ABOUT THE SERIES . . . . . .

Mindful of the increasingly diverse needs of our growing elderly population and aware that persons in service to the elderly must be informed of these rapidly changing patterns of human needs, a community education forum dealing with aging issues was developed by Metropolitan Commission on Aging during the Fall of 1976.

The educational series called "Issues in Aging" was supported by the New York State Office for the Aging through funding to MCOA in a Title IV Training Grant given under the Older Americans Act. Metropolitan Commission on Aging, as the designated area agency on aging, is responsible for the planning, evaluation and coordinating of services for elderly residents in Syracuse and Onondaga County.

On July 1, 1974, MCOA became the area agency for Syracuse and Onondaga County. In this present capacity, the agency functions under a legislative mandate of the Older Americans Act of 1965, as amended, providing a system of funding for the distribution of services depending on the various titles of the Act. Specifically, Title III funds community services programs for the elderly; Title IV supports training and research programs; Title V develops multi-purpose senior centers; Title VII operates the Senior Nutrition Program; and Title IX includes support for the Senior Community Services Employment Program for the Elderly coordinated by MCOA.

"Issues in Aging" was prepared and presented in cooperation with University College of Syracuse University. The 8-part series met for two hours at noontime in a "Brown Bag" format on the third Thursday of the month at Peck Hall, University College, beginning on November 18, 1976. Programs began with a half-hour lecture, followed by audience participation in small-group discussions which focused on the lecture topic in relation to local community services, and concluded with a question and answer period.

Lecturers included Louis Hausman, Jonathan A. Weiss, Dr. Raymond Vickers, Monsignor Charles J. Fahey, Dr. Donald Watkin, Hobart Jackson, Roberta Spohn and William Oriol. They addressed topics of nutrition, legal and protective services, mental health, minority and urban elderly, senior advocacy, media policy, consumer information, and national policy concerning older Americans.

Moderator for the series was Roslyn Bilford, Executive Director of MCOA, with assistance from Hidde VanDuym, Director of Continuing Education in Gerontology at University College. JoDean Orcutt, a member of the MCOA staff, was editor of this lecture booklet.

Every effort has been made to keep the lectures faithful to the intent and style of the speakers. We have tried to maintain the spirit and informal quality of these sessions, reflecting the impromptu nature of spoken English.

This anthology of eight lectures is presented to the Central New York community in the hope that benefit will come from further consideration of these vital issues both today and in the future -- to act as a record of our concern that quality services be available for senior citizens in our community as they pursue their given right to a comfortable and personally satisfying lifestyle as Older Americans.

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INTRODUCTORY ISSUE: MYTHS ABOUT AGING -- WHAT AMERICANS THINK OF OLDER PERSONS.
Louis Hausman, Director, The National Media Resource Center on Aging of the National Council on Aging, Washington, D.C.

SOME BACKGROUND ON THE SPEAKER . . .

Louis Hausman brings to his position as Director of the Media Resource Center a diversified and highly successful background in communications. He was associated with Columbia Broadcasting System for twenty years, serving as Vice-President of radio and corporate Vice-President. In 1962, he became general executive at National Broadcasting Corporation in charge of public information, advertising, corporate information and promotion. He has served as Assistant to the U.S. Commissioner of Education and was a recipient of the Peabody Award for an information project on television programs for children. In 1973, Mr. Hausman became Vice-President in charge of information and education for the Washington, D.C. Council of Better Business Bureaus. He joined the Media Resource Center in 1975 and has been active in recent public information projects sponsored by NCOA to alter current attitudes toward aging and senior citizens.

LOUIS HOUSMAN:

There are 31 million Americans 60 years and older. They constitute the single largest minority in the nation -- more of them than there are Blacks or Chicanos of all ages. This minority, since 1900, is growing at twice the rate of our total population. The way in which these older Americans are viewed by society as a whole, by younger persons and by themselves has important implications for all of you concerned with the well being of older persons. To determine these views, NCOA Commissioned the Louis Harris study appropriately called "The Myth and Reality of Aging in America". More than 4,000 persons coast-to-coast participated in this survey which was first released in the Spring of 1975. Since then, the report of the NCOA-Harris survey -- now in its third printing -- has been extensively quoted in all the media and serves as a basic resource for professionals and students.

In the next 20 minutes or so I would like to decribe briefly --
First, some of the myths and facts about aging as revealed by the NCOA-Harris survey and how these stereotypes are damaging both to our society and to older persons.
Second, to discuss the media's influence in regard to these myths; and then to describe how the NCOA Media Center works with the media to eliminate the stereotypes of older persons.

SOME FACTS AND MYTHS: Let's start by comparing some myths about retirement and the Harris findings on this issue.

MYTH: Older persons should retire at a fixed age.
FACT: Harris reported that 86% of those 18-64 agree that nobody should be forced to retire because of age if he wants to continue working and is still able to do a good job.

MYTH: People look forward to retirement.
FACTS: Four out of 10 men were involuntarily retired, did not retire by choice. (A third of the women were involuntarily retired).

MYTH: They don't want to work, they're glad to retire.
FACT: Thirty percent of those retired or unemployed wanted to work. (It's

interesting to speculate that this figure might have been much higher if many older people had not accepted the notion that they ought to retire at a fixed age.)

Clearly, the picture of older persons looking forward to old age and retirement is a stereotype that is contradicted by millions of older persons who have been arbitrarily retired because of calendar age. And now I'd like to take you through the myths and facts about another important issue-- fear of crime among older persons as a "Very serious problem". When asked what people consider "very serious problems" affecting older people, the Harris study revealed a number of interesting items:

ONE: There was substantial agreement between those under 65 and those over, that fear of crime was "a very serious problem" for the aging. About half of each age group felt this way.

TWO: Older persons when asked about how they felt about the importance of this issue to themselves personally, less than a quarter felt it a "very serious problem".

One more set of numbers from the question of crime as a very important issue: Like in so many other issues, income is a key factor. The fact is that it's tough to be poor -- no matter what your age.

The survey allows us to break down the fear of crime as a "very important issue" by income levels and age groups. When we do this we find--

ONE: About a quarter of all groups earning less than $7,000 a year felt this a "very important issue", regardless of age. Actually in this income bracket, the 18-54 year olds felt it slightly more serious than the 55-64 or the 65 and older group.

TWO: In the $15,000 and over bracket, fear of crime dropped to less than 10 percent for the two younger groups. It did rise to 17 percent among the 65 and older segment of the sample -- still significantly below the general concept.

The question about the fear of crime illustrates not only the sharp differences between how younger people view an issue concerning older persons, but also the difference between how older persons view themselves and how they view other older persons. And it demonstrates what most of us would suspect: that income has a major influence on problems among people of all ages.

THE DISADVANTAGED AGING: The Harris survey makes one thing supremely clear: Older Americans are not a homogeneous group. They are individuals, come in all shapes and sizes with all kinds of needs and capabilities. Just like younger people.

Fact is that the only common denominator of older people is that virtually all are, in one way or another, disadvantaged. There are the physically disadvantaged -- those millions who are feeble and ill with not enough money for adequate housing, medical care, food, clothing, transportation. Help for these, as you know far better than I, lies in fiscal support for such programs as home health care, increased Social Security and Medicare benefits, housing, transportation, and food stamp subsidies.

Then there is another category: Those millions who are psychically disadvantaged. They are healthy, reasonably well off, but have been segregated from the rest of society by the accident of calendar age -- eager and competent though they may be to continue participating in the society by doing the many kinds of useful work that their energy and wisdom and experience uniquely qualifies them for.

The plight of these psychically disadvantaged older persons parallels the plight of women and blacks. It is summed up by *Caroline Bird* in her book, *" The Case Against College,"* when she says;

> *"Like everyone else in the 1950s and 1960s, I used to think that the troubles of Women were personal- to be dealt with by psychoanalysis if necessary. Now we all recognize that the malaise of Women and Blacks are normal responses to the limited role society has assigned to them".*

That same malaise, the forced acceptance of a limited role in society, affects millions of older Americans.

CAPABILITIES OF OLDER AMERICANS: One reason that older persons are being pushed out of the work force is the way society views their capability. Obviously, it is not the only reason, but it is a powerful factor in age discrimination. It is the same type of misperception that for so long kept -- and still keeps, in too many cases-- women and blacks from being able to contribute their talents to our society.

The NCOA -Harris survey illustrates dramatically just how older persons have been inaccurately stereotyped:

> *Only 19percent of those 18-64 consider older persons "as very open minded and adaptable;" only 29 percent viewed them "as very bright and alert;" and slightly more than a third saw them "as very good at getting things done."*

This negative stereotype contradicts flatly Department of Labor studies revealing better attendance records and less job dissatisfaction among older workers. It is contradicted by longitudinal studies showing there is no gradual decline in ability to learn as one grows older; learning ability is not represented by a Bell curve; it continues well on in years and only as the result of a disabling illness does it drop off sharply.

Consider what this stereotyping says. It says, in effect, that a typist who types 90 words per minute, suddenly, at age 60 or 65, goes to hunt and peck. That a top mechanic no longer can diagnose the problems of a car or a television set once he gets to be older. Clearly, such perceptions are false. Unfortunately, truth is what you believe. And the acceptance of such stereotypes is damaging not only to the individual but to a society which prides itself as one nation indivisible-- not subdivided by sex or race of age.

ROLE OF MEDIA: All of us know the power of the media -- its ability to influence as well as to reflect our society. Today we live in an age of instant and universal communications. The nightly television news makes all of us involuntary eyewitnesses to war -- complete with sound and in real-life color. Radio brings us even greater immediacy. And, in case we don't know how to appraise the significance of what we have seen and heard, there are the syndicated columnists to help us -- in newspapers in Little Rock, and San Francisco, in Battle Creek and New York City, in Syracuse and points in between. The effect of this immediacy on our attitudes and perception is incalculable --but very real.

Nor is the way we think and act influenced only by hard news. It is affected continuously by exposure to feature stories in magazines and newspapers, daytime serials, nighttime situation comedies and dramas. Our attitudes toward morality, the way we dress and the way we view ourselves and others is subliminally affected by the entertainment world-- as well as by the advertisements. To an enormous extent, we are what we see and hear and read in the media. Our prejudices, the ideas we support or reject are shaped, reflected and modified by the media. And no nation in history has ever been exposed to as much information and entertainment as the American people today. The media have been extremely useful to you in raising the consciousness of their various publics to the needs of the feeble elderly who are physically disadvantaged.

Frequently, and at your instigation, they have carried stories, featured in news programs and in broadcast documentaries, the plight of tragic older Americans, hungry, ill-housed, and in need. But until recently, there has been no significant media exposure of the capabilities and activities of older persons who are actively contributing -- for wages or as volunteers -- to the needs of their communities, and finding fulfillment for themselves in these activities. These are the psychically disadvantaged. How to assure equal media representation for these strikingly different groups may strike you as a dichotomy. It is, but it is a necessary one. And the only way to face up to it is to recognize that the need of both groups should be served-- for both groups are equally important.

STEPS TO ERASE MYTHS: About three years ago, The National Council on the Aging recognized the need to take steps to erase the false stereotypes about older persons. To have them viewed for what they are: a heterogeneous group some of whom are bright and energetic, some who aren't; some competent, some not. Just as these differences exist at all levels from early childhood on. Only by having older Americans accepted for what they are can they serve society as an integral part of our national resources. Accordingly, and with the active support of the Edna McConnell Clark Foundation, NCOA established the Media Resource Center. Its mandate: to help and encourage the media to portray older people for what they are -- to serve as a catalyst for the reduction of stereotypes. Let me tell you something of three major projects we engaged in: newspaper columns, Senior Citizen of the Month Award and the Advertising Council Campaign. We developed a weekly column called GOING STRONG. Each column profiles the activities of an older person -- a person who, if you believed the myths -- should have been retired to bingo playing and television watching. There is no dearth of persons who flatly contradict the myth. They span a wide range. They include Hoyt Catlin of Norwalk, Connecticut, who started a nursery business when he was 65, and today, at 85 continues to run his factory. The average age of his employees is 68.

Also profiled in one of the columns was Louise Soelberg, 72, of Yellow Springs, Ohio. She was a ballet teacher who now teaches riding to handicapped children -- an accepted form of therapy. These columns serve as a model for other older persons, they make potential employers aware of the 21 million older Americans as assets to their companies, and they stimulate local editors and writers to do similar feature stories. This column started in July 1975 with 16 papers and 123,000 circulation. Testimony to its success is that today, some 350 newspapers across the country carry the column each week, with an estimated circulation of 3.5 million.

Another activity reinforcing the goals of the Media Center is the "Senior Citizen of the Month Award". It is co-sponsored by NCOA and the Kentucky Fried Chicken Family and the award is based on the theme "Ability is Ageless". It has received wide coverage by the press, including AP pictures. Winners include Fred Noble, 92, of Jacksonville, Florida, a student and lawyer; Marshall Cheney, of Santa Cruz, California, who runs a job placement service for older persons -- all of whom have been previously profiled in the GOING STRONG column. The winners are selected by a panel of judges including such persons as former Justice William O. Douglas, former U.S. Senator Margaret Chase Smith, broadcaster Hugh Downs and columnist Ann Landers.

A major project is the all-media NCOA/Advertising Council campaign, Older Persons: A National Resource. This advertising currently appears in newspapers, magazines, transit advertising, radio and television -- both local and network. This advertising campaign is directed primarily to those between 30 and 50 years of age. These are the people whose attitudes toward and perception of older persons need to be modified. For two reasons:

1) *These people are potential employers. They can do something about work for Older Americans - as volunteers or for pay.*

2) *These younger people have a real stake in changing the stereotypes since they too, will be old sooner than they think. (If they're 35 years old, chances are 9 out of 10 they'll live to be 60.)*

This NCOA Advertising Council Campaign, delivers some $22 million worth of donated advertising by the media. It represents a breakthrough for the cause of aging since the Advertising Council receives some 400 requests a year from various causes and supports only two or three new ones a year. This campaign is considered significant by the opinion leaders of our society -- advertisers, labor, academicians and the media. It focuses on the social importance of educating our society about the realities of aging. The third major Media Center project centers on television's entertainment programs. There is probably no more powerful an influence in shaping public perception than the entertainment programs of network television. If women are depicted in television programs solely as sex symbols, and blacks as fumbling subservients, this reinforces the viewers' stereotypes of women and blacks and helps solidify them. Similarly, with the way older persons are portrayed -- in speech, in action, in mannerisms. Accordingly, and through the financial support of the Markle Foundation, the NCOA Media Center was able to open a West Coast Office in Los Angeles. The head of this office is Helyne Landres. Her role is to work with the writers, producers, and directors of network television programs to present a more balanced picture of older persons. Miss Landres, with her wide circle of friends in Hollywood, was exceptionally successful in this effort when she worked for the Population Institute.

An example of her missionary efforts is the scripting of an episode in M*A*S*H*. In this planned episode, the commanding officer -- after being told by his younger subordinates that he is too old to perform a complicated operation, he successfully does it. One other item: The U.S. Department of Labor which classifies older workers as those 45 years and older, has called on the Media Center for the past two years to prepare material for its annual "Hire the Older Worker Week". This includes a television spot and next spring you will see a new -- and very effective one -- which we have prepared for their use. To describe in any detail other activities of the NCOA Media Resource Center would be a misuse of your time. Suffice it to say that the Media Center responds to those in the media who come to it for information and guidance. It stimulates the media to devote a portion of its space and time to fairer representation of Older Americans.

TO SUMMARIZE: There are millions of older Americans who are able, wise and eager to continue contributing to the unfinished work of our society -- either as volunteers or for pay. Yet, those who can make use of older persons' experience and energy are prejudiced against them --just as they believe, in one degree or another, the myth that calendar age is the dividing line between capacity and incapacity. Even though this myth is contradicted by all the available facts. Based on everything we know about where people get their attitudes, the Media Resource Center has mounted programs with the media -- to show by example the falseness of these stereotypes.

The Media Center's activities are directed primarily to those who are going to get old -- rather than those who are old, themselves -- even though these activities help the aging in terms of their self-image and self-respect. There is evidence that these effects are paying off. Evidence of such awards as an Emmy to Art Carney for his role in the movie Harry and Tonto. In television programs more older persons are being portrayed realistically in situation comedies such as Phyllis. And the print media are responding with increased space devoted to stories of active Older Americans

It won't happen all at once. It won't work in every instance. But, it is urgent that age or sex in job consideration becomes as irrelevant as race or religion. On the subject of religion -- as a question in job application forms -- there is this story. It is the story of a job applicant who went through a long questionnaire which included everything, including his grandmother's maiden name. At the very end of this job application form was the question "Church Preference?" The applicant thought a while and then, with great deliberation, wrote down "Red Brick".

SECOND ISSUE: CURRENT LEGAL PROBLEMS OF THE ELDERLY -- WITH PARTICULAR EMPHASIS ON PROTECTIVE SERVICES FOR OLDER PERSONS. Jonathan A. Weiss, Director, Legal Services for the Elderly Poor, New York City.

SOME BACKGROUND ON THE SPEAKER . . . .

Since 1969, Jonathan Weiss has been Director of Legal Services for the Elderly Poor. Previously he has served as managing attorney for the Neighborhood Legal Services in Washington, D.C. and New York City, and was associated with the Center on Social Welfare Policy and Law at Columbia University. Mr. Weiss has been a legal consultant to numerous programs... Office of Economic Opportunity, National Institute for Education in Law and Poverty, White House Conference on Police Community Relations, National Senior Citizens Law Center, Moreland Commission on Nursing Home Reform and the Senate Committee on Aging. He has been a guest lecturer at many universities and is a frequent guest on network talk shows.

Mr. Weiss is the author of two current publications entitled, *"The Law and the Elderly," and "Reflections on Poverty and Pain."*

JONATHAN WEISS . . .

I'd like to give a brief review of the problems that confront the elderly in the legal world. They are incredibly complicated. Many problems are connected to programs which attempt to alleviate them, but-- in fact -- do not.

Let's look at two categories of these programs. The first are programs which are supposed to do something for the elderly. There are a large number of public benefit plans which are intended to give benefits to which people are entitled by virtue of a combination of factors -- their age, past working record and economic status. The most important programs include the following: Social Security, some middle security income known as SSI, railroad retirement benefits, medicare and in all states counting but one, medicaid. Also, in varying degrees there are programs of unemployment insurance and home relief programs which periodically come into effect. Now all these programs have a number of serious defects in common, some which are susceptible to litigation and some which are not -- all of which are obviously susceptible to legislative change. To begin with, all these programs have complicated eligibility requirements. That is, in order to qualify for the benefits in these programs there is a whole mass of bureaucratic requirements that older persons have to go through. Quite often, these requirements are misunderstood by the people who require them, with elderly not told what they must do for certification. As a result,many older persons give up what is legally theirs. Here is a recent illustration:

A case in our office involved the following situation. It took SSI ten months to put our client on the federal program; at the end of those months he was entitled to a check of $1800 he took the $1,800.00 and spent it slowly over the next ten months. At that point the Social Security Administration discovered that during these ten months our client, because of this retroactive check, had money in excess of $1,500.00,as was allowed in the program. As a consequence they informed our client that he had a resource at that time and was not eligible for all the ten months of subsequent SSI checks,

and because he didn't spend that money right away when he got it, SSI was attempting to recoup all the money given our client over the past ten months. Complicated and confusing? I think our case can be called a classic Catch 22.

This is not an unusual situation; we can sit around and tell these terrible stories which are funny, but not to the older person to whom it happens. Most programs have some sort of strange regulations. Under SSI for example, when an elderly person goes into the hospital for more than a month,his benefits will be cut down $25.00 -- of course,he can't pay the rent on the apartment he left, thereby losing the apartment and having to pay much more for a new apartment, with the rent raised on a flat grant system. The next sort of problem with these programs is obvious -- they don't pay enough money. Medicare pays roughly 40% of total elderly costs in this health area; the rest are sustained by older persons. Anybody who gets a social security check knows it is hopelessly inadequate. There are also other things that happen. Sometimes increases in social security force older persons to lose their entitlement to medicare - medicaid and food stamps. Theoretically, one program gives you money but another takes it away. This issue was unsuccessfully challenged in Colorado,all the way to the United States Supreme Court.

It has become fairly clear that Social Security is not the answer to all the financial problems of the elderly in our country. So, as an inducement to employees to work (recognizing when they were retired or manditorily retired, and not receiving adequate income from Social Security), companies started distributing brochures which said -- "Look at the wonderful pension plan we have." It is usually always a little black and white picture of a happy couple setting off to Europe surrounded by champagne and happiness. Well, the estimation is that approximately 20% of people expecting to get pensions actually receive them. Some of the cases we are litigating now are receiving national coverage, such as the National Maritime Union special school run by Maritime Union pension funds. "Sixty Minutes" recently did a show saying precisely what we said in our complaint: that the money paid into the pension plan was being used to further objectives of the president of the National Maritime Union, with a school to create a monopoly for union members to get jobs in various places. There are also a number of devices used in pension plans to cheat people out of what they expect. The first one is that pension plan literature often doesn't tell the truth. Even though you may read in your brochure one thing, it may not be, in fact what you're getting. Literature of this type is not a legally binding document; I myself think it should be, and we have litigated and are litigating this in various places. Then there are "Technical Devices" invented for the implementation of pension plans. One is the doctrine of "veste" which means that you have to work a certain number of years before you have any right to the plan at all. Traditionally, this is 20 years. A firm can fire you with 19 years & a month, and you will be ineligible for a retirement plan. Another is the doctrine of "breaking service". If you were sick for a year, or took another job for a year, you are not eligible to string together a consecutive twenty years. Still another device is "portability". Suppose you worked in a program wherein they change your funding source and your contract. (This happens in the electro-dynamic industry where you have one government contract one year, and it is changed to something else the next.)
Pension programs say it's not the same source of funds,so the years cannot add together. We call this a lack of "portability."

The second category -- things which are done to elderly -- reflects the basic problem in this country resulting from the terrible treatment I described in the first category. I am talking about a pervading sense of age discrimination. When someone is past a certain chronological age,our society considers them dead because we believe they've lost all of their abilities. Somehow when you reach a magic number such as 65 and you are no longer working, you are no longer of value.

Let's regard where the number 65 came from: When Otto Von Bismark was trying to beat back the advances of the Socialist Party, he decided to enact his own Social Welfare Plan, and this plan took effect at the age of 65. The thing is, at that time the average life expectancy was 32. In the United States now it's roughly 70. Age discrimination is pervasive, we have across this country mandatory retirement going down in decreasing age. The United States Supreme Court, mainly due to the initiation of four appointees, recently upheld the following mandatory retirement. One of the officers of the Police Corps in the State of Massachusetts was 50 years old. He had passed the physical and whatever exams given policemen with the highest grades, but at 50 he was considered too old to be a policeman, and was fired. The United States Supreme Court said everybody knows people lose their grip when they get older. Another claim was since he's 50,it really can't be quoted as age discrimination because the officer is only middle-aged. Actually, this makes no sense at all. The age discrimination Act of 1967 discriminates also; what it prohibits is discrimination between the ages of 40 and 65.

Age discrimination spills over into another category which is the whole area of what is considered the proper standard approved necessary to commit someone to a mental institution or say they're unable to take care of themselves. For example, built into the Social Security Law is something we're now challenging called the "responsible payee". If someone tells Social Security you don't use your social security check properly,they can suspend payment until they find somebody called a "responsible payee" who would be the sheriff of a town, a brother, or almost anyone. Under Social Security regulations you don't even have the right to challenge the person who is the "responsible payee" -- it could be someone who hates you. Four years ago, we won a case which said people have a right to a hearing before they take the money away from you. Another part of the age discrimination doctrine is when someone younger inherits a great bundle of money and spends it drinking champagne surrounded by young chorus girls, that is called sowing his wild oats. If, however someone 60 or 65 is not managing his financial affairs well, we take his money away from him.

There are a number of statutes that presumably deal with the good of the elderly person. The most vicious one in this area is a statute that the Nixon Administration passed for nursing homes. I assume you all know there are a lot of difficulties in the area. This particular one is called "Utilization Review" which I claim basically means mass murder. Under utilization review, every six months a nursing home administrator must send papers to people in the hierarchy concerning medical assistance programs. On the basis of those papers the Medical Assistance people decide if an older person is receiving too much care in the nursing home.

If they decide the senior is receiving too much care, they immediately order that he be transferred to what is called an intermediate care facility, because obviously he does not need the amount of care. The problem here is that studies have demonstrated that, given certain sets of circumstances, the mortality rate shows about fifty percent of the people who were transferred this way died within six months. We have now written a law that says before you transfer them out you must first hold a hearing. At the hearing it is relevant whether the effect of the transfer will be to kill the person. We have a great deal of trouble enforcing this in most states. We now have injunctions in Florida, New Jersey, and New York. Time will tell. It is morally wrong to address this issue by the concern for how much money the state can save by transferring elderly patients without first looking at their ability to withstand the transfer.

It is apparent in this brief overview that the elderly have to confront complicated and seemingly endless legal problems. We can and must begin to clarify these problems. This afternoon, I haven't covered all the important areas; I've just begun.

THIRD ISSUE: THE ELDERLY AND MENTAL HEALTH -- WHERE ARE WE NOW? Dr. Raymond Vickers, Director, Geriatrics Unit, Capitol District Center, Albany, New York.

SOME BACKGROUND ON THE SPEAKER . . . . . .

Raymond Vickers, M.D.,is an Associate Professor in the Department of Psychiatry at Albany Medical College and a Unit Chief of the Geriatric Screening Team, Capitol District Psychiatric Center.

Dr. Vickers came to the United States from Great Britain in 1955, serving as a research fellow in internal medicine. He received his psychiatric training in Kansas and was appointed team leader in the Geriatric Service Unit at Fort Logan Mental Health Center in Denver. Dr. Vickers came to Albany in 1968, to take part in the preparation and pilot work for the Capitol District Psychiatric Center. He is certified as a specialist in internal medicine by New York State, and is also listed as a qualified psychiatrist. Dr. Vickers feels that his work in geriatrics relies on a knowledge of both the emotional and physical aspects of adjustment to later life.

Dr. Raymond Vickers . . . . .

I want to present four issues for your consideration -- The first issue is "custodial". I'm going to talk about problems that include the hackneyed phrase "alternatives to institutionalization" as well as institutions themselves, with particular emphasis on nursing homes. The second one is "about the medical profession" because I'm a physician. When I say medical profession I mean all those other professions that are allied with us, like nursing and social service, and other health related professions. The third one I'm going to talk about is "research." This involves science and some educational aspects for those of you interested in education research. The fourth one I'm going to talk about is "social affairs",meaning cultural community affairs.

The real reason for the ideal behind an institution for the elderly is probably best expressed by one of the more memorable phrases of the former President Nixon when he referred to nursing homes as "warehouses for the dying". I think that this is brought out by the death rate of people after they've entered nursing homes--which you may know from the Duke studies showing that 80% of people admitted to nursing homes were dead within 5 years, and 50% were dead within 3 years. Old people correctly recognize that the nursing home rather than the hospital is the place where you go in vertically and come out horizonally. This being so, people look for alternatives not only to bigger institutions such as mental hospitals which are for mentally ill people but also alternatives to nursing homes which are called by some mental hospitals for elderly.

My friend Alan Goldfarb in New York has reported that 87% of people in nursing homes in New York have diagnosable psychiatric illness so that nursing homes are places of interest to those with interests in mental health. The real reason people need a nursing home rather than a real home is that they cannot cope. Most of the disabilities that place people in nursing homes involve an inability to cope. Of course, inability to cope has changed in this century very much for two reasons. At the turn of the century there were only 3% over 60 in our total population, now there are 10% or 11%. As a result, for any one family there is a much greater probability of parents and grandparents who need the support of the family system than there was at the turn of the century.

We sometimes hear from people that there must be a change in morality because in the old days young people used to take care of the elderly, but with the large families at the turn of the century there might be only one oldster to take care of. Only 3 out of 10 people were cared for by the remaining 97 people. That meant old people could get into a relative's home relatively easily. Whereas now the average young couple without children might have 3 or 4 elderly people who are disabled. Even at the turn of the century they weren't expected to do that. So there is no cultural change; it is a mathematical change.

Family support systems are not currently available to help people cope in the way they did in the past. This has been referred to in Alvin Toeffler's "Future Shock". Today an older person has to know how to handle long distance dialing, touchtone phones, dialing for information with telephones--just to get in touch with his relatives. The same thing applies to fresh frozen foods that are in packages persons with arthritis can't open and are written in instructions in such minute print that no older person can read. I could go on and on describing the same old person with the same disability could not have coped at the turn of the century even without family support systems.

Then, there's the 5% fallacy. The 5% fallacy refers to the fact that if you take all the old people in institutions, count them and compare them with population of all people in the community, it comes out as 5%. So it seems from this fact that very few old people are in institutions, say one in twenty. The fallacy is that, that occurs only at one time. If you remember what we said about the death rate and the fact that old people reaching age 65 have an average life expectancy of 17 years, greater for woman than men, then sooner or later the ones who aren't in the 5% now are getting to the 5%; fallacy rule works out to 22%; 22% of all people finish up in nursing homes or other institutions. This is significant.

Because of the death rate many old people do not want to go into nursing homes. Families don't want them to go into nursing homes because they feel guilty. All sorts of peculiar things happen to families; for instance, they quit visiting because they can't stand the guilt. Nursing homes then become isolated in the way that the old state hospital used to be isolated up near the St. Lawrence River. Even when nursing homes are in the middle of the community, if you look at the size of a parking lot outside a hospital with 400 beds, you'll see what I mean about the isolation of the nursing home. There's no provision for other than staff because the relatives just don't go except on Sundays.

Then the authorities, the people at Albany located across from me in the State Capitol, they don't like nursing homes because they are very expensive. They cost anywhere from $30 to $40 a day and they say that's too much. Now I compare a good, clean, nice modern nursing home with a motel room. They look rather similar, they have the same industrial carpet and the same modern type furniture. The cost is still forty dollars a day whether it is a motel or a nursing home. In fact, considering how nursing homes provide the meals and the staff for the same amount that the Holiday Inn charges you for a bed and room, it makes me feel that thirty to forty dollars a day is not excessive. Therefore, our community should be prepared to pay nursing homes if people need to be there because of a disability. However, studies show that anywhere between eighteen and thirty percent of people in nursing homes do not need nursing home services. They've been sent there by what I call automatic referral of hospitals. That is, if you go into a hospital and you're elderly, the social worker fills out a nursing home referral form because she is afraid that you will run out of your medicaid days and the hospital will have to pick up the difference.

And so she gets the nursing home form made. Old people are transported to nursing homes sometimes involuntarily,which is against the New York State Law, but nevertheless often done. Instead elderly could have returned to their homes with supportive recovery services. But we should be able to provide for more needs than just the biological needs which, after all are provided for in a home for pedigreed cattle and dogs. In fact, if you read the state requirements for pedigreed cattle you find they read very similar to the state requirements for nursing homes: fire sprinklers, temperature of the hot water and things like that.

There is no human measure of nursing home needs : we should move from the bioligical to the humanitarian needs. What are the alternatives?

A well trained home health aid may make five to six dollars an hour, four hours a day that's still only twenty four dollars a day which is a lot less than forty. It is a one-to-one interest, which elderly most likely don't get in an institution. For those that have special needs there are day care centers. We have a two-level day care center at our psychiatric center in Albany. The lower level is for people with mainly social needs who have mild chronic brain syndrome. They come in with memory problems, forgetfulness. We treat them with a social program where they're happy, doing all sorts of nice things. You know in this city you have some of the pioneers in day care. We have a second level which you don't have and our critera to enter to the second level are like your critera for not entering the day care which is that they would be too difficult to work with. These are people that formerly would be sent to the state hospital.

We now have them in day care and they shuttle to and from their homes, or sometimes halfway houses and hospitals where they live at night.This is a very cheap form of care compared with hospitals, state hospitals and nursing homes. Then there's a great need as all of you recognize for intermediate care in home facilities available. This is a real challenge. How can we get away from just allowing the state to cut eligibility to nursing homes for people who are psychiatrically disturbed which is grossly unfair since 87% as I say, of nursing home populations have mental illness already ?

A second issue I'm going to talk about is medical, and I can't say much about it except to say aloud something that you all know but do not talk about. This is the extreme lack of knowledge in the medical and health-related profession concerning the psychiatric aspects of aging. The current index of this, for instance, is the large number of elderly people diagnosed by physicians as having brain syndrome due to cerebral arteriosclerosis. That is the commonest single diagnosis made of mentally ill elderly people. I can say with some authority that that diagnosis almost cannot be made during life.

"CHRONIC BRAIN SYNDROME" is a syndrome consisting of defects in memory, defects in judgment, defects in emotional control, and defects in orientation, all of which are required to constitute that syndrome and any one such as memory loss by itself does not constitute the syndrome.

The arteries of the brain are so difficult to examine and the techniques we have are so uncertain that one cannot tell that a person has arteriosclerosis of the cerebral arteries. Everyone who writes this down as a diagnosis must clearly be an extremely astute diagnostician and must have some very sophisticated electronic and expensive equipment or has a patient who has established brain artery disease like a stroke or is just guessing on good luck--after that, it's a self-fulfilling prophesy.

If everybody makes a diagnosis of cerebral arteriosclerosis as a cause of cerebral changes, then that becomes the commonest diagnosis. If you make the commonest diagnosis, you have a bigger chance of being right. We teach our medical students that if you make a rare diagnosis you're more often wrong than you're right. Consequently this cerebral arteriosclerosis business covers up the kind of ignorance that the medical profession has about this. Geriatrics was not taught because there have been so few geriatric patients in the past. Now we offer some post-graduate courses in it, but they're not well attended -- or necessarily up to date, because people assume with the elderly that they know all about their problems. That's a kind of certainty that always goes with ignorance. So it was in the 20's about pediatrics, and the medical profession resisted.

The General Practitioner used to say: I'll look after the entire family, there's no need for a speciality called pediatrics. Look at it today, most parents prefer pediatricians for their children. In the same way, geriatrics has a lot to say about the mental illnesses that can take place in late life.

The commonest psychiatric condition of the elderly, as every person who knows mental illness knows, is depression. And this can be proved and treated. But chronic brain syndrome which I mentioned before is untreatable, in the sense that it cannot be reversed. Most depressions, about 92% of depressions, are absolutely reversible with treatment. But if you don't make the diagnosis of a treatable condition, you'll find the medical profession, the hospitals and institutions saying, "There's nothing more we can do".

It is not inevitable that you'll have memory loss when you grow older. In fact, people have memory loss at every age. When you're a child they say you did not learn your lesson, when you're a young teenager they say you're in love, and when you're my age they say you're an absent-minded professor, when you're old they say you're senile. It's the same memory loss but having it when you're old frightens people. And you know the funny thing about forgetfulness is if you realize you're forgetting you get the panic state which insures that you never can remember, and the harder you try the worse it gets. The only way to remember things you're forgetting is to change the subject, slack off your mind and sneak up on it from behind. Some old people learn that, but not many do. We train psychiatrists that there are three main groups which I call ABC, NBC, and CBS. ABC are Acute Brain Catastrophes, that is strokes and the like, things that suddenly happen, they're rare and they indicate arteriosclerosis of the brain.

They are treatable because in a sense after each catastrophe with proper rehabilitation the person makes some recovery but never back to where they were. CBS, or Chronic Brain Syndrome, is a steady progressive illness which results in more severe forms in total dementure. NBC, is Non-Brain Condition, a constant state of mental disability. A study in San Francisco showed that of all cases referred to psychiatric clinics more than half have medical conditions which are misdiagnosed. If these medical conditions are treated properly the cerebral conditions disappear. Diabetes, renal failure, liver disease, hypertension, heart failure, many other conditions, result basically in cerebral symptoms. Every old person suffering from mental illness must first be checked by a good internist, who with good procedures corrects whatever medical problems the person has.

A related problem is drugs since nowdays we have ten drugs for every illness instead of in the old days when they just had opium. Some old people have made interesting studies for me when I visit their homes. If you go to their bathroom and I always ask to go to the bathroom, I look in their cupboard, and it's full of course, with drugs. Sometimes each of the diagnoses has three or four drugs, so old people may have 20 or 30 drugs that they are taking at one time. If you take away most of these drugs, in many cases the mental symptoms disappear - because they are due to the side effect of the drugs. The commonest drug prescribed in the United States is Valium. Valium is poison to elderly people and almost invariably produces changes in attention, sleep patterns, memory, and other things. So it's not surprising that elderly people have drug problems. They also have alcoholism and who wouldn't with the situation they find themselves in -- without adequate care because you know how we look down upon alcoholics.

Now I'm running out of time so I'll just do headlines on the last two. **Research:** Obviously there's some hope in this. We may make some moves. My good fellow Englishman and friend geriatrician, Alex Comfort who has made a million by selling *THE JOY OF SEX*, and who is really a geriatrician, has written a book, called *THE GOOD AGE*, which I recommend you read, in which he describes all the good news about aging. He believes, and I don't, that as you keep making discoveries, you'll live longer. I hope we don't. Perhaps some of the people who die young would have been able to reach the good age as he calls it. That is what aging research really is about. There is some fascinating material on memory which suggests that the loss of memory in late life can be overcome. I can't go into this, but if you can imagine the difficulty one has if you get snow on your television screen, it is thought that all people with loss of memory still have the picture, but they can't get it due to the snow, due to the interference. In fact the brain is not degenerated, it is due to extra activity of the brain coming in front of the picture. The last possibility in research which is very exciting is that senile dementia may be due to a slow virus and is an infectious disease. Researchers have found a version of senile dementia which is definitely due to a virus, but it only occurs in the cannibals of the south sea islands, and only in the women in these tribes. It's because when they cannibalize a person the men eat just the testicles and women eat the rest of the body. Now they're looking for the virus everywhere else except in the testicles, which I think is appropriate.

Finally the issue that cuts through all of these, -- and I'm glad to know that you had the Harris Report explained to you -- Is the business of prejudice against the aging. The social and cultural issue of agism, like racism and sexism, is the real barrier that the aging suffer, because it results not just in isolation, but in loneliness. They are alone in a crowd, we do not see the aged. The aged are more numerous in our population than they've ever been before, and we have developed the ability not to see them. The older person really suffers from two conditions in a significant degree, as the Harris Poll showed, and as any old person will tell you. One is health problems, and the other is forced retirement. The whole economics of the health field is related to these two things: The loss of income from the elderly by retirement, and the cost of health care. These are the issues; it is unfortunate we have no more time.

FOURTH ISSUE: WHAT IS OUR PUBLIC POLICY CONCERNING OLDER AMERICANS? Rev. Msgr. Charles J. Fahey, Member of the Federal Council on Aging, President of the Board of the American Association of Homes for the Aging, and Director of Catholic Charities, Diocese of Syracuse, New York.

SOME BACKGROUND ON THE SPEAKER . . . .

Rev. Msgr. Charles J. Fahey is a native of Syracuse and has served in many pastoral assignments in the area. He has been associated with Catholic Charities since 1961, and was made Director in 1967. Father Fahey currently serves on the Boards of Health Systems Agency, Group Hospital Service (Blue Cross) and MCOA. He is a former member of the ALPHA and CHIPS Boards, among others.

On the national level, Rev. Msgr. Fahey was a participant in the 1971 White House Conference on Aging, acting as Chairman of a Special Session on Long Term Care. He is currently a member of the Board of Directors of the National Conference of Catholic Charities. He has made numerous appearances before committees of Congress, and has lectured at colleges and universities throughout the country. Father Fahey has acted as a consultant to Offices on Aging, the National Institute of Mental Health and the Gerontological Society. He has been recently appointed by Governor Carey to the New York State Public Health Council.

In 1972, Father Fahey was honored by the American Association of Homes with the Aging National Award of Honor.

REV. MSGR. CHARLES J. FAHEY . . . . .

It's a real delight for me to be with you and see so many familiar faces. As I said here last Friday with a similar group,it's somewhat intimidating because what I know has come largely from folks like yourselves and from some of you personally; and despite my religious identification, I steal liberally from your ideas and what you're doing, and I brag actively in Albany and Washington about the kinds of things that we are doing here in Syracuse.

I am always ambivalent when I see familiar faces because after all, we all have only one talk that we give, and we give it over and over again. I am reminded of what happened to me when I was first ordained; I was an assistant up at Saint Vincent's on the hill, and for whatever reason, they put me on the circuit and I gave a talk to a Catholic women's club called the Catholic Daughters of America. I talked in Oneida and I did well there, so they invited me to Rome to speak. I apparently did okay; then I spoke at Camden; then I spoke to the Catholic Daughters at Fulton; then Oswego. I suppose having served my apprenticeship and done well enough, they finally invited me to the big time to speak in Syracuse, and it was one of those days when I was particularly harried and I got there late right at dessert time, and as I was just trying to get a few thoughts together, you can imagine how I felt when the toastmistress got up and said "we'd like to welcome as our very special guests this evening the Catholic Daughters of Oneida, the Catholic Daughters of Rome, the Catholic Daughters of Camden, the Catholic Daughters of Oswego". So, I feel a little bit like that today.

Now, what I want to share with you and what the charge is, to talk about public policy issues in the field of aging. I thought it would be useful to try to put things in the context of how public policy is structured on the Federal level, what is the current climate in Washington as far as aging is concerned, and what are some of the specific issues that are going to be on the agenda. Then,if time permits, to speak in the same general way about State government. All of you who are professionals touch hurting and lonely elderly, isolated and alienated older people in a very direct way. A lot of this has to be only in direct, personal, friendship, or familial relationships. Yet, as perhaps no other group in the population, elderly are affected deeply by impersonal public policy, if for no other reason than because of the public policy that encourages in some instances or absolutely demands in others that people retire. You and I know the ordinary way by which people gain resources to live in our nation is by being producers. Since we do not need older people to produce goods, or services, we have instituted mandatory retirement -- not so much for the benefit of the individual, but rather, for the benefit of society. And so this society that throws people out of the work force often ill-prepared psychologically and certainly economically, has a very special responsibility to these older folks from a public policy point of view.

Participation of the Federal Government in this area is something that is relatively new. In the middle of the last century there was an extraordinary person who happened to be a woman, who went throughout the breadth of the land publicizing the plight of the "insane" and the deaf. Her name was Dorothea Lynn Dix. Congress was so moved by her portrayal of the absolutely dismal conditions of the asylums of that period that it was moved to appropriate ten million acres of property, the proceeds of which would go to the support of the insane; likewise 225,000 acres of land for the care of the deaf. President Pierce vetoed that measure as an inappropriate encouragement of the Federal Government in what is basically a local responsibility. This general philosophy concerning the relationship of the Federal to the State prevailed until the middle of the 1930's when the mass of problems facing the country forced the evalution of certain federal measures. Yet even the earliest of the New Deal efforts were declared unconstitutional until President Roosevelt was able to develop a Supreme Court more in tune with his philosophic and political outlook on life. Since then, there has been a tremendous proliferation of activities in the Federal Government as far as aging is concerned. I would suggest to you, however , that viewed together, they are rather simply stated. The fundamental assumption under most federal acts concerning aging, would be first and foremost, that aging people are either vertical and well, or horizontal and sick. That is one of the fundamental elements. Secondly, it's basically a cash or an income strategy even when it comes to services. The underlying philosophy tends to be how can we give income support to elderly people.

There are basically three ways in which the Federal Government programmatically deals with local problems. First of all, there are certain areas of human activity that are so close, so akin to life, liberty, and the pursuit of happiness, that we say people ought to have these things available to them so that these common rights will not merely be an empty phrase. For certain people who are situated in certain circumstances we create entitlements, that every person in the United States with certain kinds of vulnerabilities may have an entitlement to certain kinds of assistance.

The second general way in which the Federal Government works with local communities about local problems is to say,"there are common needs sometimes so over-riding and so massive that there is no way to create entitlements for individuals, but to develop program stimulation through categorical grants usually designed with some sort of a carrot approach to encourage action, either through government or voluntary effort on the local scene." And so we have all kinds of categorical programs sometimes going through state government--involving State matching programs, and sometimes going directly from the Federal Government to individuals. The Metropolitan Commission on Aging, its utilization on the Older Americans Act and all of its programs would be an example of the categorical program that involves the intermediary of the State. On the other hand, when it comes to the development of housing for the elderly, that is basically the Federal Government putting into the hands of individuals and (in the case of Section 202) non-profit groups, the ability to meet the housing needs of people. So we have a variety of these programs in no way designed to meet all of the needs of a particular category but rather to meet some of the needs. The third and last general way the Federal Government approaches human needs on the local scene is to put dollars into ordinary local decision-making situations. In some ways this is the newest of all social support activities and we call it revenue sharing. It is predicated on the fundamental assumption that the taxing power of the Federal Government is the most progressive and least regressive of all tax systems. The basic philosophy of revenue sharing is that instead of having the federal program develop the entitlements or create programs through categorical grants, they would restore to local communities the ability to develop their own programs. Revenue sharing has been in existence for about five years and unfortunately has posed little in terms of programmatic support for elderly people. It has tended to stabilize the tax base as represented through sales tax, and in some ways helped to stabilize the necessity to tax property and therefore -- at least indirectly -- has helped elderly people, since 70% of elderly people own their own homes.

All that I have said is sort of a remote background. Now let's get more particular. There are fundamentally four areas in which the Federal Government takes cognizance of problems of elderly. The first is in the form of income maintenance. There are two fundamental ways under income maintenance that the Federal Government functions. The first which is the bedrock of our social policy and the most significant of all pieces of social legislation (at least in my mind), is the Social Security System. We transfer 75 billion dollars a year through the Social Security System. It is at the very foundation of the social fabric of our country, and despite what some rather irresponsible people would say in regards to the system, it is an extraordinarily important entitlement technique created by our prior participation in the work force. All of us who are gainfully employed at the present time are in the Social Security System. We fully expect that what we are paying today will be the creation of an entitlement for us in the future as far as fundamental income is concerned. We also decided in a very important way in the beginning of the 70's that we should have a guaranteed annual income for certain persons within our nation who were unemployable by reasons of physical or mental disability, blindness or more particularly by reason of age.

This is the basic philosophy of Supplemental Security Income (SSI). While we have yet to match with dollars, the philosophical commitment inherent in SSI is an extraordinarily important principle and an extraordinarily important program.

The second area in which we have created entitlements is in the field of health; again, it is important to recognize that our efforts in the field of health at least as far as elderly are concerned, have had little to do with health programming. We have assumed that elderly people will use the same tecnhiques, the same resources, the same type of provision of services as anyone else in the population. Our strategy in regard to health has been to afford elderly the ability to pay for health care, and we have done it in two ways that parallel the two income systems. We do it through Title XVIII called Medicare which is absolutely parallel to Social Security. We create an entitlement for ourselves for certain fundamental health services by our prior participation in the work force and by our payment of taxes. The one thing that's different under Title XVIII is that there is no difference as far as level is concerned. If we need a particular service that is covered under Title XVIII, then we receive the full benefit whether we were at the lowest or the highest scale of participation in the Social Security System. We recognize that there is also another difference. There is a part B to the Medicare System, which presents an option for those people who wish to buy certain non-covered services under the fundamental coverage, particularly in the area of physician services and some additional home care. Parallel to Supplemental Security Income is a federal state means tested program that we call Medicaid -- a staggering program in its size and its scope. The Federal Government mandates certain fundamental types of programming and eligibility levels, but it is up to the states to develop their own program, but they differ from state to state. There must be at least five coverages of hospital care, nursing home care, physicians visits, and certain kinds of outpatient care. But there can be as many as 19 services covered under Medicaid, and virtually all 19 have been covered in New York State, although with the Fiscal crunch that we have at the present time there is a tremendous regression in the area of scope of coverage as well as eligibility for Medicaid. So we have income maintenance, Social Security and Supplemental Security Income; and absolutely parallel to them Title XVIII Medicare (provision of payment of health services), Title XIX (provision of health services for poor people much broader in its scope of coverage than is Title XVIII.)

On the social service side of things, we basically have two approaches. The year 1965 was a very important year for the field of aging, because two of the principle statutory systems that we're dealing with were developed--namely Medicare and Medicaid and the Older Americans Act. The provision of services for elderly people from the federal perspective is basically through two differing and somewhat similar fronts. One is the Older Americans Act with its various titles, the largest of which are Title III and Title VII. The Older Americans Act pays for the development of state offices on aging, and also provides monies for the development of local offices on the aging under non-profit auspices, municipal auspices, county auspices, or whatever. There are some 600 area agencies on aging throughout the United States, whose basic mission is to serve as coordinating, planning, and leadership groups in the field of aging. Also through Title III of the Older Americans Act, there is a modest amount of money for demonstration (seed money types of projects) and for the development and sustenance of informational and referral services.

Title VII of the Older Americans Act, supports the nutrition program, and is the largest single title of that program. The other principle source of services for the aging, is Title XX. Title XX has a fascinating history. I would like to take a minute to talk about it. Title XX is basically a program that is means tested, and tied into the public assistance system. Its roots go back to 1967, when social workers went to Congress and said "if you give money for services, we'll get people off welfare". I'm really not sure that we had the ability to deliver, but we said that was what we were going to do. So, they evolved a program at that time including purchase techniques for the proliferation of services basically for people who were on welfare, had been on welfare, or who were liable to be on welfare. Actually the fullness of that program was not realized at first, and things went rather quietly for several years, with a rather modest expenditure of funds primarily in day care for children. It was a highly lucrative program in the sense that there was a $3.00 Federal match for every dollar evolved by the State, and this was open-ended funding. Whatever bill States presented to the Federal Government the Federal Government had the responsibility to meet it on a three to one basis. The State of Mississippi recognizing a good thing when it saw it, took all persons who were in any state program (mental hygiene, corrections, youth, whatever..) and weeded out those people who were welfare--those who might be on welfare, had been on welfare, or were on welfare, and developed purchase of service agreements within State Government. Here was found a transfer of responsibility from the taxpayer. And of course where Mississippi was to lead, California and New York were quick to follow. We found a tremendous proliferation of what in effect, was a federal service revenue-sharing program in an absolutely runaway situation. Actually, the Federal Government did not know what to do about it, so the first thing they did was to slap 2.5 billion dollars sealing on the program. Then there was a debate as to how to structure the act. The result of all that debate is Title XX. One of the last admendments to Title XX was introduced by Senator Kennedy which called for every state plan under Title XX to provide at least for three of the services for people eligible under SSI. Typically the services that have been funded are homemaker services, day care programs, and things of that sort for elderly people. So under Social Services supports we have a modest amount of money; 2.5 billion dollars is the total expenditure for the whole of the area of Title XX. By the way, Titles I through IX of the Older Americans Act, we find the expenditure to be something like 500 million dollars. That is also a rather modest amount.

The fourth area of at least some federal participation is housing. Since the original community development acts following World War II, there has been an uneven commitment to the field on housing in general, and specifically to the field of elderly housing. There have been various grant programs to local housing authorities for the development of housing that have largely dried up. There have been various assistance programs to non-profit groups that dried up, particularly during the Nixon years when an income strategy was substituted for a building strategy. At that time, individuals were given supplemental funds to purchase their own housing and Section 8 types of funds were developed. At the present time there are modest funds available under Section 202 non-profit groups and local communities developing specialized housing for the elderly. There is a Section 8 program which supplements rental fees on the local scene. So that's the Federal scene. Four general areas: income maintenance, payment for health services, modest social services under Title XX, and the Older Americans Act, and Housing under HUD, primarily through Section 202 and Section 8.

There are also certain public policy areas where the Federal Government participates relating to the protection of rights. They have nothing to do with the expenditure of money, and so there is continuing interest both in the regulation and the field of statutory activity concerned with various rights of people. For example, at the present time there must be ten bills in Congress about mandatory retirement -- dealing with things of that sort, about age discrimination, pension programs, protection of individuals who are in various pension programs, etc.

At present, what's the climate in Washington? On the one hand, from the structural point of view there seems to be a concerted effort to place in decision-making roles people who had demonstrated competence and commitment to helping people, and that is a very encouraging note. We see many fine people being encouraged to participate in the Federal Government. However, there's nothing like the great society programs or anything of this sort. Efforts are perceived to be very modest. President Carter said at the Department of Health, Education and Welfare what he had said in other departments, that he has a commitment to the American people to have a balanced budget by the time he leaves office and so there isn't a tremendous amount of new monies available, but rather it is a question of shifting priorities, both within existing structural arrangements and among various efforts that we make on the national scene. So, how much new money that will be available for any human services -- say in the field of aging -- I suspect, is modest. To have any unrealistic hopes in this regard, I think would be doing ourselves no service.

There are several areas that will be of concern to us. The number one priority of the current administration is welfare reform. SSI certainly will be a subject of consideration during this period, to analyze its effectiveness, and to try to modify the things that need modification. SSI will also probably serve as a model for some sort of a program to take the place of Aid to Dependent Children. There are task forces under way and the President has made a commitment that this will be a number one agenda item. Secondly, the Older Americans Act is up for renewal this year. The Administration on Aging will make its suggestions in the next couple of weeks. A hearing process will be initiated later in the year; it is scheduled to be acted upon in the fall of the year. So now is an appropriate time to give consideration to the Older Americans Act, and the various provisions therein. There seems to be little movement from left to right, Republicans or Democrats, to greatly modify the Older Americans Act, but rather to sort of modify certain provisions therein. The third area is national health insurance. We have a lot of concern about this because of New York State and the problems we have here. Again, there are a couple of things that have crippled the national health insurance debate. Specifically, I cite the list point system, and the prohibitive costs of this program. It is obvious that since 1965, with the introduction of Medicare that the health field has been inflated enormously. Costs in the health field have progressed at a rate of at least twice the general cost of living, and there is serious concern that the large numbers of dollars fused into the system will merely expand these inflationary flames. The other problem is in order to get a bill or a statute passed, the principle issues have to be so identified that they are understandable, intelligible, and debatable. The National Health Insurance package is so complex, even to the technicians, that it has not been able to be debated in a reasonable fashion.

The major difficulty with it is that as soon as you pull out one piece to look at it, you suddenly realize if you do anything with that piece, a piece over here is going to be affected. Political scientists are viewing the whole debate with a great deal of interest, I'm sure. I think the timetable of the administration is October. President Carter wants to present a bill on the national health insurance. The one thing that has marked the national health insurance debate to this point is that all the provisions affecting the elderly are crummy. That virtually none of them from the most conservative to the most liberal do anything substantial for aging persons, aging services, long term care or mental health. They tend to throw up their hands in despair in all of these areas.

So these are the three principle areas of concern -- the Older Americans Act, Income Maintenance and The National Health Insurance. All of those things will be under discussion within a general context of modest expectations and a hesitancy to spend much more money. I started with the Federal level, and I won't talk much longer, because almost everything we do on the State or Local level is within the context of those Federal statutes, with the exception of some modest funds for recreation that formerly were dispensed through HEW and now are through the Office on Aging. There is virtually no state initiative other than conformity to one or another of these statutes. This brings us back to New York State, and our own local area -- which is where I began.

FIFTH ISSUE: PRICE AND PRIDE: AND OTHER PRECIPITANTS OF ELDERLY MALNUTRITION. Dr. Donald M. Watkin, Special Assistant to the Director for Health and Medical Affairs, Administration on Aging, Office of Human Development, U.S. Department of Health, Education and Welfare, Washington, D.C.

SOME BACKGROUND ON THE SPEAKER . . . .

Dr. Watkin has been a professor of medicine and nutrition at Tufts, Columbia, Boston University, Johns Hopkins, Howard and George Washington University, and in Great Britain. He has been editor of Nutrition News and the American Journal of Clinical Nutrition, and has published extensively for the past 15 years in the areas of public health, biology and nutrition.

He has been an advisor to the Pan American Health Organization and Chairman of the Technical Committee on Nutrition at the 1971 White House Conference on Aging. Dr. Watkins has participated in nutrition surveys in Pakistan, Libya, West Indies, Peru and Paraguay.

He was field director for the 1968 New York State Nutrition Survey, and was Vice-Chairman of a Panel on Aging at the 1970 White House Conference on Food, Nutrition and Health. He has acted as Senior Investigator with the National Heart and National Cancer Institutes. Dr. Watkin served in various professional roles with the U.S. Veterans Administration and is currently on detail from its Department of Medicine and Surgery.

DR. DONALD WATKIN . . . . .

I have been asked to talk to you about the problems of malnutrition in older people, and I'm going to try to give you the point of view which I have evolved over many years of looking at this problem and many years of listening to the testimony of older persons themselves, leaders of organizations that are devoted to the problems of elderly people and also to professionals in various specific disciplines who have had an opportunity to work with the elderly throughout their professional lives. First of all, let me make clear that there are on a world-wide basis two varities of malnutrition. One is called primary malnutrition and is due to an absolute lack of food in a particular area at any given time. We have had some examples of this in recent years associated with the drought at the Southern border of the Sahara Desert, and over a long period of time in such diverse places as Bangla Desh and Northeast Brazil, to mention only a few. The other form or variety of malnutrition is malnutrition which is secondary to disease or disability. This disease or disability may be physical, it may be emotional or mental, for it may represent the end result of an attitudinal pathology. At present in the United States, fortunately, primary malnutrition does not exist. We have not only plenty of available food but also have huge surpluses of food which are now being used to maintain our balance of payment system by exporting it abroad. Yet secondary malnutrition does exist and is in effect the only kind which we find among the nation's elderly today. It has, as I mentioned earlier, physical, emotional, or mental and attitudinal roots.

The physical diseases that lead to malnutrition are well known to most of us. These include cardio-vascular disease and various forms of peripheral vascular disease. They include also renal problems and various difficulties of evacuating the urinary tract. Endocrine problems such as diabetes, hyper-and-hypo-thyroidism or adrenal cortical insufficiency are also problems which can induce malnutrition. Many digestive diseases are in this category. These include oral and dental pathology including poor prosthesis or poorly fitting dentures. Esophageal pathology runs the whole gamut of gastral, intestinal and liver-oriented disturbances. There are many anemias such as those due to blood loss due to infections, cancer, uremia and nutritional deficiencies. There are neurologic disorders, whether inherited or acquired. There is the whole field of neoplastic disease or cancer. There are pulmonary diseases. There are the problems of visual, auditory, gastrology and olfactory pathology which may lead to malnutrition. Arthritis is another prominent cause. Then there is a whole range of disabilities which result from accidents and finally among this list are the complications resulting from prior surgery. Many of these physical diseases which lead to malnutrition can be prevented by the application of good nutritional principles throughout life. Other physical diseases may be treated successfully, at some interface with the health industry to produce an optimum state of health.

The prevention and/or treatment is largely a function of first, education, and secondly, the availability of health care. Now both education and health care are available in the United States today, provided individuals assume responsibilities for finding them, or are assisted in finding them by others if they are indeed unable to find them themselves. Emotional or mental illnesses also contribute to malnutrition. Among these the most common are depressions or the opposite. Among the elderly one of the forms of mental illness which has received a great deal of attention is the "chronic brain syndrome", one type of which, so far, has been declared to be irreversible. Now these diseases of an emotional or mental nature may also be treated effectively, provided they are recognized in the older person, and provided they receive appropriate treatment. One important treatment is nutrition and another important treatment in dealing with the elderly, is effective therapy with drugs--not to mention what may be done in the long run by more expensive psychotherapy.

The final element of disease and disability which I want to speak of, I've called attitudinal pathology. This, I feel, is responsible for much of the malnutrition which has been identified in the elderly today. One attitude leading to this malnutrition is the acceptance by many elderly persons of the concept that the food they eat is the most compressible item in their personal budgets. Ahead of nutrition, they place the cost of housing, utilities, transportation, maintenance, of household equipment, and certain, absolutely health-related expenditures. This attitude has been reinforced by the roughly 35% increase in the cost of living for elderly couples reported recently by the Bureau of Labor Statistics between 1971 and 1975. In 1975 the Bureau estimated that food costs required or should require about 30% of the retired couples' budget. However, these statistics were estimated for retired couples based on projections arrived at by applying the consumer price index to figures collected for the last time in 1969. This was the year when the panel on aging at the White House conference on food, nutrition, and health referred in its preamble to its recommendations to the President, "There is a present crisis in health, nutrition, and income maintenance among the nation's elderly".

The answer, therefore, to the inflation problem, and with its accompanying extreme compression of food budgets, lies in changing attitudes on the part of the elderly through education. First elderly persons need to learn how to maximize their resources with which they finance their retirement. This includes taking advantage of all possible income maintenance resources available to them. These include sources of cash such as retirement plans, social security, supplemental security income, legal tax exemptions, food stamps, and state-funded public assistance programs where these are appropriate. It also means utilizing the full range of services to which they may be entitled. Then, perhaps, the issue of elderly malnutrition can be addressed. Even so, we have a large job ahead of us.

SIXTH ISSUE: AFFIRMATIVE ACTION AGENDA NEEDED FOR ELDERLY OF RACIAL MINORITIES.
Hobart C. Jackson, Executive Vice President and Director, Stephen Smith Geriatric Center, Philadelphia, Pennsylvania.

SOME BACKGROUND ON THE SPEAKER . . . . .

Hobart Jackson is the Chief Executive Officer of the Stephen Smith Geriatric Center, the oldest facility in the country providing care and services for the Black Elderly.

A recognized authority in his field, Mr. Jackson was a member of the Executive Committee of the 1971 White House Conference on Aging. He was Chairman of an Advisory Council on Aging for the Senate Special Committee on Aging. He is the founder and immediate past Chairman of The National Caucus on The Black Aged, and was the first Director of The National Center on the Black Aged.

Mr. Jackson has testified before committees of both houses of Congress, and served on commissions dealing with problems of Black Elderly for three presidents. His papers on aging have been published by the American Association of Homes for the Aging, The National Council on the Aging, The Gerontological Society, The National Health Council, The National Conference on Social Welfare, and The University of Southern California.

HOBART JACKSON . . . . .

I bring you greetings from the Stephen Smith Geriatric Center in Philadelphia, and from the National Caucus on the Black Aged, where we are attempting to push for affirmative action efforts in the field of aging throughout the aging network. When you think of the plight of the black elderly in this country, it's really going to be extremely difficult to bring order out of a very complicated, very difficult situation, considering all of the situations involving age, race, poverty and the kind of multiple jeopardy to which they are subjected. I do feel that problems of black elderly are somewhat of a microcosm of the total problems in this country. We will not make a lot of progress in the resolution of those problems until we begin to move more substantively on these problems which are basically human.

While preparing my remarks for this presentation I encountered a relevant headline in the Philadelphia newspaper several days ago which said, "the rich get richer and the poor get poorer." The Chairman of the House Banking and Finance Committees said the just-released census figures for 1975 show that while no income group kept pace completely with higher prices, low and moderate income families suffered most. He noted that the inflation rate in 1975 was 7%, but income for families in the bottom fifth of the income scale averaged only $6,914.00, an increase of only 4.3% over the previous year. Most families involving old blacks would presumably fall into that category. He also said that the number of poor persons grew by 2.5 Million or 10.7%, the largest single increase since 1959. The 40% of Americans with higher income have increased their share of the national income steadily since 1968. If America is to realize her ideal of equality,we must get our income distribution working towards equality, not away from it.

The newspaper article continued, "During the Truman and Johnson administrations between 1947 and 1968, Americans in the lower 40% income level improved their share of national income from 16.9% to 18%, and that is certainly progress at a slow enough level. But between 1969 and in 1975, during the Nixon and Ford administrations the lower 40% declined back to 17.2%, not too far from the 1947 level. The higher income 40% did just the reverse, with the middle remaining relatively constant."

Let us take a look at some of the special concerns that older blacks have at the national level. We can begin this process by pointing out just how many there are, and their approximate rate of growth. The numbers of black elderly increased 1.6 million in 1970, from 1.2 million in 1960. That was an increase of 400,000 or 33 1/3%, and that was a more rapid growth than enjoyed by their white counterparts. The actual current number of blacks over 65 is estimated to be about 1,800,000. Blacks have a lower life expectancy than whites, resulting from the generally lower socioeconomic status that they are accorded in this country. Although comprising almost 12% of the total population, blacks make up only 8% of those over 65. The effects of institutionalized racism in this connection seems to fall more heavily on black men. A recent census bureau report reveals some gains in life expectancy by blacks, but black men who have an average life span of about 62 years still don't live long enough on the average to collect that social security. Other life expectancy figures show 70.1 years for black females, 68.4 years for white males and 76.1 years for white females, who outlive all the rest of us. Black women outlive black men to an increasing extent. In 1970, there were only 76 black males for every 100 black females in our aged black population. (I'll state it in another way, there were 131 black women for every 100 black men over 65.) But one of the most unfortunate, yet significant things about that fact, is that the proportion of women to men is increasing. This disparity and its increasing impact represents one of the most socially poignant problems that we face. Because of this great inbalance we must begin to think of ways to better serve elderly black women who are alone, or certainly have no husbands. In addition, there is a larger percentage of older blacks than whites who do not live with their spouses. This has been attributed by some to the great economic pressures on families -- including public welfare laws which encourage black men to leave home early in life.

It has been estimated that about 60% of the elderly in the United States live in substandard housing. Some 80% of the black elderly are subjected to this inequity. This is largely a result of outright poverty based on marginal income. Some of the elderly live in public housing which is seen by them as a highly desirable resource in view of the wretched alternatives available. Finally, many oldsters are so poor that they cannot even afford public housing. According to one study, only 3% of the tenants living in federally subsidized housing for the elderly under private sponsorship are black, and two-thirds of these live in black-run developments, leaving about only 1% in so-called integrated housing, and yet these developments are federally subsidized. We feel this is a gross inequity.

Poverty, like substandard housing, is typically a part of age. People who were poor all of their lives can expect to become poorer in old age. But they are joined by a multitude of people who become poor only after becoming old. And although older people represent 10% of the total population, they constitute more than 25% of the poor in America.

We produce a new generation of elderly poor every year, even with SSI. In order to keep the problem in perspective we should remember that 85% of the elderly poor are white. A greater proportion of the black aged however, are poor and that probably is more profound. But there are truly many more in actual number poor who are white than black. The brutal fact is about one-half of the black aged are poor, compared to not quite one-quarter of the white aged.

After age 65, older people earn 29% of their income. Availability to work is hampered, as you know, by two major factors -- the social security ceiling on earning and age discrimination in employment. Black aged men participate in the labor force in the same proportion as do whites, but earn less doing harder physical work and are in poorer health. Black elderly women are more likely to work than white women, indicating that greater need to support themselves or supplement their husband's earnings. They, like black men, earn less usually doing domestic and service work. Retirement by choice is less of an option because black retirement benefits are often meager in line with their previous low earnings. Indeed, there may be no benefits at all.

It has been observed by many that staying out of an institution is not as big a problem for older blacks as getting into an institution when one is really needed. Nursing homes and homes for the aged remain largely segregated even though segregation is usually not stated openly on the policy. A recent report of the United States Senate Committee on Aging concerning the nursing home crisis, documented my estimation that only 2% of nursing home residents and patients are black. Whites do not generally apply for admission to black homes and white homes usually claim that they have not received any qualified black applicants. Black owned and operated facilities tend to have great difficulty meeting health, fire, and building standards. They may be closed rather than given assistance and encouragement. It has just been brought to my attention by the United Methodist Church of the closing of a black home in New Orleans, Louisiana. Now, the Methodist Church only sponsors two predominately black homes in the entire country. One of these is in Baltimore, Maryland, and the other is in New Orleans. The one in New Orleans has been closed because of the life safety situations, even though the Methodist church has already developed a plan for a new building. That new building is in process, but in the meantime the home has been closed and some of the residents of that home -- mind you -- have been relocated as far away as three hundred miles. The devastating impact of that sort of thing is quite obvious, and certainly from our point of view is a much more dangerous kind of a situation than the risk of fire or whatever. Many nonprofit church-sponsored homes avoid integration by restricting admission to their own parishioners, already to some extent a self-selected group in terms of race and class. I might say that there are efforts underway to remedy this situation. One of these I think that will bear some fruit is an affirmative action program that has been instituted, by the American Association of Homes for the Aging. (I referred a little earlier to Monsignor Fahey, I see he is now in our audience. He is the President of that organization, and I happen to be one of its Vice Presidents.) When a black older person requires institutional care, routinely state hospitals and county government institutions are the only facilities available. But the practice of closing institutions because they do not meet standards, especially those that are serving a predominately poor population instead of developing a program that will enable them to excel in their performance, has resulted in the systematic erosion and deterioration of services to black and poor people. I might say it was one of President Nixon's nursing home improvement programs where all of this got started, and rather than being an improvement program in our view, has resulted in not only a lowered public image with reference to institutional care but has also actually reduced access to these needed services.

Both research findings and personal experiences document the inescapable conclusion that health and other life-sustaining services for the black aging and those of other minority groups are grossly neglected. They are denied the services that are in principle available to them. Good health care and services are viewed as rights and not privileges.

Now let us look at some of the specific programs and services, along with some of the techniques and strategies of our advocacy efforts. With the trend in the Administration on Aging toward decentralization to the state units on aging and area agencies on aging, we feel that a tremendous amount of work needs to be done with these agencies to make them meaningful to older black persons. Among the positions which we have enunciated is that all programs, services and facilities that are subsidized by federal funds should serve the black and other minority elderly at least to the extent of that population proportion in the community service. Preferably more than that because of the multi-dimensional aspect of their problems. Certainly staff and commissions of state units and area agencies also need to involve blacks and other minorities in this same proportion through affirmative action efforts to achieve this kind of balance. We have received this kind of commitment. As a matter of fact, the affirmative action program is now part of the regulations governing the instrumentation of Title III and VII. We did receive a similar assurance from Dr. Arthur Fleming, the current Commissioner of the Administration on Aging. The influence of his office will be helpful in supporting this throughout the aging network. But we do have -- all of us -- a responsibility to monitor these agencies to see that they live up to this kind of a commitment. The National Urban League has recently received an Administration on Aging grant designed to do some monitoring in this area. As you know, the National Urban League is probably the one black organization that would have enough local affiliates that could tie into an aging network.

There is a desperate need to target the special problems of the black elderly. I was recently in New Orleans for a meeting of the National Center and National Caucus on Black Aged, along with various educators and others who deal with minority training and research. We felt that a higher proportion of the funds under Title IV of the Older Americans Act ought to be made available to predominately black institutions, so that more equity could be introduced into that program. The Supplemental Security Income Program as you know, got under way on January 1, 1974, setting a new national economic floor for the elderly. The big trouble with this program, despite its conceptual validity, is the fact that the income floor established is so miserably low. In addition, massive confusion still is a part of its implementation and administration, and has hampered rather than facilitated getting new enrollees on the books. Unfortunately, its implementation has resulted more in guaranteed annual poverty across the country than a guaranteed annual income. There are some states, of course, that have supplemented the program and have brought the program above the poverty level. But in most of the states throughout the country this is not the case. Again, because of its conceptual validity, I think all of us have a responsibility to try to help in the implementation of the program and to be sure to get enrollees on the books who are eligible.

Another federal program often talked about which has little or no meaning for the black elderly (or, for elderly in general) is revenue sharing. Only the politically sophisticated and already powerful really benefit from this program, not the people who need the services the most. We are certainly enamored with the prospect for potential in this program.

When one initially contemplates the problem of responsibility for serving as advocates for the elderly and minority groups, perhaps an initial reaction is to develop an organization such as our National Caucus on Black Aged, and I believe that this is an approach which makes the most sense and can get the job done. There is the belief that perhaps all that is needed is someone to speak out in behalf of or with the minority elderly, to give visibility to their special problems, and to work to get those problems resolved. A deeper look into the situation reveals the issues that we are concerned with and working toward improving (i.e., the quality of life for aging minorities) are in general, the same issues that face our total society. Their resolution will determine the future course of this country. When I contemplate the many, many things that need to be done in our society, to guarantee the moral rights and entitlements of the elderly and minority groups,I must advance without equivocation the thesis that advocacy for this group is the responsibility of all of us -- every American.

The story of the black elderly is one of heroism, strength and fortitude in the face of fantastic odds. Despite multiple hazards and multiple jeopardies, they continue to play a valuable role in maintaining togetherness, stability, and cohesion among black families.

Justice for anyone must be the concern of everyone. We must in some way retain the impassioned belief in the invincibility of the human spirit when wedded to the imperishable ideal. Not by might, not by brute power, but by the spirit and grace shall we overcome. If we really believe this, a better world may emerge around us through a building of effective coalitions for action and change, and all of us will be better off for the experience. And our great country which in many respects is now in deep trouble, may really be safe.

SEVENTH ISSUE: ISSUES INVOLVING THE URBAN ELDERLY -- CRIME, THE FRAIL ELDERLY, HOUSING AND TRANSPORTATION. Roberta R. Spohn, Deputy Commissioner, City of New York Department for the Aging.

SOME BACKGROUND ON THE SPEAKER . . . . .

Roberta Spohn has been a Deputy Director for the New York City Department for the Aging since its inception. Mrs. Spohn is a sociologist and Public Administrator who has worked in the fields of health, housing and social services. Prior to joining the Department for the Aging, Mrs. Spohn worked in the Model Cities programs of the Human Resources Administration and as a Social Planner for the Housing and Development Administration. For ten years, she was a sociologist with the American Nurses Association.

Mrs. Spohn has taught at the New School for Social Research and Fordham University.

ROBERTA SPOHN . . . . .

I have some caveats whenever I talk about older people, and that is, to begin by recognizing their incredible diversity. There is a real problem in trying to plan or think about a group that may vary from 60 to 90 years old. That's a 30-year time span. No one would think of planning for a group of birth - 30 years, likewise, there are whole generations from 60-90. You must have it here in Syracuse, we have in the city, an acute awareness of the incredible diversity within those 30 years. But nothing can be done without being very much aware of the economics of the older person, his ethnic background, his racial background, the kind of community the person lives in, the kind of informal supports, and the kind of formal supports. To attempt to plan, and in our case, it's for over a million people, without beginning with the fact that we are dealing with a tremendously diverse universe, is a great mistake. So I begin with that caveat -- care for the diversity among the aging.

I would like to share with you way I view the problems of our senior society. I grew up in a cash, carry, and envelope world. What did it mean? It dates me because my mother is 77, four years older than the average age of older people. Cash, carry and an envelope meant that my father came home from work on Friday night, he gave her the paycheck, and she divided it up --$ .50 for the insurance man, $2.00 for the rent, so much for this and that. After all the envelopes were filled, somebody came around and collected the money. It was very simple. The insurance man came and you gave him $ .50 and he gave you a receipt. Then you went to the grocer. That is the way we lived. I think it's terribly important because there are carry-overs that cannot be changed. When I go back to that cash and carry world, what I am saying, is that older persons today, despite the diversity, did not grow up in a consumer society, and did not grow up in a credit card world. Above all, the world they grew up in was a world where God was alive. and there was no computer. I am convinced though the talk of God is dead seems to be over, there is a new God in our society and it is called the Computer. It is omnipotent. It can determine what you receive from government and what you shall not receive from government. What we have created may be all right for the young, because they are growing up in a world of the plastic charge card. For the older person, however, what they are suddenly confronted with for the first time in their life, is a world of ID cards and a number associated with it. And because of that ID card, there is a whole series of forms which ultimately must be punched into a computer.

An older person in this society is suddenly faced with the fact that they have a Social Security card, an SSI number, a Medicare number, and they might be eligible for food stamps. In order to receive these basic entitlements which we think they are eligible for, we have set up a whole series of bureaucracies with which the older person is totally unfamiliar. Being old in a society today means dealing with a world of bureaucracies which is a totally alien kind of concept. Some of our older people have become sophisticated, some of them can and do have a checking account. But most of the older people I personally know, and most of the older people in New York City, only know a savings bank. The only kind of a check form that they ever have used is to send a postal check to a relative in the old country or to one of their kids. Bankers wonder why older people won't put their money in Social Security and have it deposited in the banks. They forget that many older people believe unless you see it, you have never had it. Remember, there was a depression and banks closed. This has not been forgotten.

Services are not always devised in terms of the realities of the older person. Many of you are aware that the State of New York in its theoretical wisdom has instituted a whole new approach to who shall be able to move into an unskilled nursing home or adult residence, who shall get home care, and how many days an older person can spend in a hospital. I don't know how many of you have looked at the forms, but one of them came across my desk, it was one of those utilization review forms. Very clearly it said to the health personnel that you are to fill out this form not in terms of your best medical and professional judgment, but in light of the laws and regulations governing Medicaid and Medicare -- a very interesting concept. You are now told to give up whatever that professional identity led to your training, to your ability, and to rate this patient in terms of X,Y,Z. Are they diabetic? Do they have to be turned? Do they this or that? If I am a diabetic, you will not know about it if I can manage my food, I can go to the doctor and I can contain it. But a diabetic on a fifth floor walk-up is a very different diabetic than someone who has a family to take care of them. All of these human issues do not appear on the form, but you do get a number and in the final analysis that very number is placed there by a person who gets it from your medical records. It is quite possible that the reviewer has never seen the older person. We are really creating a society which says -- do not bend, mutilate, or tear the card. There's nothing about bend, mutilate or tear older people, you see. I would like to share with you some of the kinds of problems and programs that we have seen in New York, and how we have to find an answer for them. I am sure you have your nutrition programs and we have ours. That is an area where I am convinced local control is fabulous; the more you get the community involved, the better it is. I am also convinced that there are marvelous people working in the field of the aging and running these programs.

I had a pleasurable experience yesterday; I visited a Title VII program where the food was incredible and the love was incredible. They delivered 30 meals a day to the homebound, some of it on foot, some of it by car. Seniors picked each other up, they mourned each other, they grieved each other, everyone cared. I walked into another center and there seniors were all lined up, and the local beauty school was in there. The students come in twice a week and they do hair. I don't know what it's costing you to get a haircut, but it costs a fortune to get your hair cut in New York City, and to have a beauty school where the kids get credit is just great.

I see another sign up on the bulletin board, and the director says that is our shopping list. We buy certain other things in quantity -- tunafish in small cans, for example. We can get it for this price. When the distributor delivers the food for our program, we order extra, and then sell it at cost to our people in the program. We all become a family again. Even in the city the size of New York, it's a city of neighborhoods, it's a city of support, there is an enormous amount of what really keeps older people going. It's isn't you or me. It's the family; it's the neighbors; it's the kids.

On the other hand, we have other problems which hopefully you do not have. We have communities that might just rip you apart. I don't know whether any of you saw the Bill Moyer show called "The Bronx Is Burning", but it is an incredible experience to drive through that area. To go through the Bronx which is a major borough of the City of New York, and literally to know what arson is doing, is amazing. Block after block of buildings in which you can see every apartment has been destroyed. I had almost become hardened to seeing things, but that bothered me. Bushwick in the Bronx is an area with the biggest German-Catholic church in the City of New York; it's a working class area. It's an area where the houses that are left had new aluminum siding put on three years ago. That says something, doesn't it? Three story houses that working class people bought and hoped to live their lives in, and suddenly there have been a thousand fires in three years. One thousand buildings destroyed. And you look into the little that's left, and you're not seeing slums, you're seeing spanking white walls that were lovingly cared for, and it is gone -- absolutely gone. The last people to leave these kinds of communities are the elderly who are trapped in that situation. If the fire is bad enough, everybody will be relocated. If you have a five story building and you contain the fire to the two top apartments, those people will be relocated, but the rest of the occupants will not. Within 24 hours the vandals will be in. Within two weeks the toilets will be gone, and the rest of the people in the building must fend for themselves. For older people, the stability of their environment is terribly important. As you face losses in older life, it is important to be able to count on your environment being stable. We had many who were Orthodox Jewish. Once the shrinkage began and the butcher moved, the old Jew had an enormous problem because he really is dependent. The synagogue moves, and then he is left behind. Communities keep changing. And then when the fires begin, you have an enormous problem.

How do we support those persons trying to help older persons with problems like I described? What is happening to the social worker? We are turning the social work profession into a profession of advocates,of people who can manipulate the bureaucracy. That's the major job that they hold in servicing the elderly. We memorize the SSI manual, we memorize the food stamp manual, we learn the Medicaid manual. The real training we give our social workers has nothing to do with human relations. It has to know whether or not we should bring that situation to a fair hearing, when should we call for the lawyers and how do we get EAA (Emergency Assistance to Adults). Recently, we had to set up a legal services program. What is that legal services program for? Once again, to fight the bureaucracy.

We in the city do have additional problems. We have such problems as knowing that for the first time, about 80,000 older people moved out of New York. They were all renters in the city and we don't know where they went. We have the problems of knowing that over the next few years the elderly population in our city will change very radically. Our suburbs will increasingly have a white population that left the city between 50 and 70.

And in New York City the minority population, the Black and Puerto Rican population will begin to age in substantial numbers. We will have a group which again has a history of poor health and low economics. More and more of New York City's older people will be on SSI and will be poor. We know that is to come, and they will not have the kind of social service establishments that other groups have had. There will not be a Jewish Association of Services for the Aging. There will be a Catholic Charity but it will not primarily represent the new constituency. The Protestant Federation will align itself with the underdog. But when it comes to the delivering of services, the Federation has other priorities. What we are going to need is a welfare establishment that will provide the types of services necessary for our "new elderly". That is the big problem of tomorrow.

FINAL ISSUE: GETTING IT ALL TOGETHER ON AGING. William E. Oriol, Staff Director Special Committee on Aging, United States Senate.

SOME BACKGROUND ON THE SPEAKER . . .

William Oriol has been Staff Director of the United States Senate Special Committee on Aging for the past ten years. In this capacity he has been involved in numerous fact-finding and investigatory efforts dealing with Federal Legislation. He has been given oversight scrutiny of all programs under the Older Americans Act. His office maintains widespread contact with aging organizations throughout the country.

He has written on the following topics, *"SOCIAL POLICY PRIORITIES: AGE vs YOUTH, THE FEDERAL GOVERNMENT, " "CONGRESS, POLITICS AND THE ELDERLY," "THE FEDERAL ROLE in CONSUMER PROTECTION," "TOTAL HEALTH AND AGING," "LEGISLATIVE CONCERNS AND NATIONAL PRIORITIES " and "FEDERAL DIRECTIONS FOR THE AGED."*

Mr. Oriol was instrumental in organizing the successful 1976 grass-roots campaign to preserve and maintain the Senate Committee on Aging. He recently developed a series of "Supporting Papers" on nursing home issues.

WILLIAM ORIOL . . . . .

This meeting has made it possible for me to be back in Syracuse, which I once accused of being a hotbed of gerontology.

That is still the case -- not only because you have such nationally known "stars" here as Walter Beattie, Monsignor Fahey and Rhea Eckel -- but also because there is so much going on that I would like nothing better than for the Senate Committee on Aging to do an inventory of what is happening in this city and county and what more you would like to see happen.

In fact, back in model city days, we did attempt to have a session at which Committee Staff could get a better understanding of what was happening, under just that one program. But as is so often the case in aging, one subject leads to several others. The same was true when I looked over the May 1 issue of the Empire Magazine published by the Syracuse Herald American. I found that I had many questions based on an article telling about the range of services and help offered through the Metropolitan Commission on Aging, and I hope we can get to them during the discussion period, if not before.

All this is by way of preamble to an explanation of why I was bold enough to call this talk "Putting it All Together on Aging". You know, there comes a time, after you have been invited to be a speaker, when a program director calls you up and says. "We're going to press: what title do you want on your speech?" I was brash enough to suggest the one listed in your program, and then a little later I looked at the list of topics and speakers you've already had at these forums and I decided that a great deal had already been put together for you. Leaders such as Hobart Jackson and Roberta Spohn and Monsignor Fahey aren't usually lacking for words and ideas and information. So please don't think I had them in mind when I said that all things would fit together nicely.

In fact, my theme today really is that presently in the field of aging in the United States there are lights of progress and shadows of old problems or new ones. Everywhere we look, whether it is Social Security or emerging population trends, there are bright spots and shadows in aging.

Before I go further into my talk this morning, however, I'd like to interrupt myself and acknowledge that you here in New York had a great deal to do with the nationwide effort which led to the Senate vote of 90 to 4 which saved the Senate Committee on Aging from death by merger in February. You fought hard against a Senate reorganization plan which would have made our Committee a subcommittee in a big new supercommittee on Human Resources. Our Chairman, Senator Church, argued against any such move on the grounds that the Committee is needed even more in 1977 than when it was organized in 1961. There are more older persons now than there were then; there are more programs to look after; and there are very clear warnings of big problems yet to come as the proportions of older persons compared to younger persons continues it dramatic growth. And in practical terms related to the way the Senate works, there were powerful arguments to keep us as we now exist: as a fact-finding committee free to cross the jurisdictions of standing committees when it's necessary to do so, but avoiding Senate conflicts and jealousies because we do not attempt to take on the legislative responsibilities of legislative committees -- the responsibility to receive individual bills and report them out. Instead we complement the work of those committees and provide the facts and advocacy that lead to enactment of needed legislation and understanding of the needs and hopes of aged and aging Americans.

To help us save the committee, you and others gave very direct help in letters, phone calls, and telegrams. Senators Moynihan and Javits were among the sponsors when Senator Church took our case to the Senate Floor on February 1, and so were 48 other Senators. I think that the solid lineup of Senators, Republican and Democratic, young and old, conservative and liberal, was possible only because of grass-roots concern. And that is why I am thanking you today. (Likewise, Senator Church's thanyous given at other times are heartfelt.) Many people spoke of saving "our committee." And that, I think, is the highest kind of tribute which can be paid to a governmental unit. And we do not take it lightly, for we know that we now have an even greater responsibility to do our job the way that you want it done.

We emerged from the struggle with a new membership. And perhaps you want the names of our members: Church, Muskie, Chiles, Melcher, DeConcini, and Domenici, Percy and Brooke.

If time permits during the question period, I'll tell you more about our work program for the year, but now I'll return to "Light and Shadows" in aging.

ADDITIONAL AREAS OF CONCERN

Just as we pounded away to make the case for retention of the Senate Committee on Aging, so we keep up the pressure to make other points, as well. We'll have to make the point, better than we have, that there are light and shadows in the Medicare program: bright achievements in terms of its guarantee of certain protections to elderly participants, but cause for deep concern over limitations in its coverage of items especially important to older persons; dental care, prescription drugs, vision needs, and so on.

Our recent achievements in extending the 202 housing program for the elderly are overshadowed by all the work that still needs to be done in providing other forms of housing. And, in terms of retirement income, the Social Security cost-of-living adjustment mechanism, already swamped to some degree by the rising prices of everything, was thrown deeper into inadequacy by the startling increases in energy costs in most of our States, even those with a more benign climate than New York, so savagely hit by last winter's terrible weather. We recently had hearings on that subject; by the way, and we were startled by reports of housing and utility bills that left only $20 or $40 for other necessities. We're trying to obtain assurance that the Carter Administration will give adequate attention to the needs of the lower-income elderly in its comprehensive energy package.

There are other areas in which light and shadows commingle, but I'd like to spend the remainder of this talk dealing with two areas which I believe are of special concern to you and your Governor.

One deals with problems caused by waste and worse, in health care programs meant to serve older Americans. The other deals with the slow progress being made in the development of so-called "alternatives to institutional care."

HEALTH CARE ISSUES

I am devoting much attention to health care in this talk because I believe that the progress and problems of the last ten years in providing help to older persons in need of health care should not be forgotten as this nation comes closer to full-scale debate on a national health insurance program for all age groups.

I'm sure you remember the jubilant reaction to enactment of Medicare in 1965; in many ways, it was a celebration after long years of struggle for some protection of Older Americans against the constant danger of financial wipeout caused by hospital bills or other costs related to health care. Twelve years after the celebration, the Committee on Aging still appreciates the many benefits provided by Medicare and -- despite all its shortcomings -- by Medicaid. But it is the same Committee on Aging which, in recent months, has:

-- Held a series of hearings sharply challenging Medicare and Medicaid policies which, in our opinion, downgraded quality of care or tilted such care in unfortunate directions, such as a "cost-plus" reimbursement arrangement which, in our opinion, helped make the New York City investigations, indictments, and in some cases -- convictions almost inevitable.

-- Also issued a series of reports based on our hearings under the general heading of "Nursing Home Care in the United States -- Failure in Public Policy". That series will, I hope, be culminated within the next few months and we will issue our final recommendations. Medicaid is the special concern in these reports, because that program, of course, pays the biggest share of today's nursing home bills. Medicare, on the other hand, keeps shrinking, and that point can best be made by a comparison: on any given day in the United States, at present, only about 8,300 people in nursing homes have their care paid for by Medicare out of the 1 Million, in contrast with the 70,000 in nursing homes on any given day in 1971.

Medicaid, on the other hand, continues to pay more and more for long-term care. Approximately 38 percent of the $15.5 Billion Medicaid program went for nursing homes in Fiscal Year 1976. Hospitals were second with 31 percent. It does not necessarily follow, however, that just because the bulk of nursing homes expenditures come from Medicaid -- and to the tune of Billions of Dollars a year -- that Medicaid must necessarily assure quality of care. And yet our series of reports about failure in public policy on nursing homes tells of abuses and waste, fires and poor control of medications, unsuitable personnel and absence of doctors, and -- in a forthcoming paper -- about high profits in some chain operations.

-- Our Subcommittee on Long-Term Care looked into kickback schemes in which pharmacists pay for the privilege of supplying neighborhood clinics or nursing homes with medication, at a considerable markup shared by receiver and supplier.
You may remember that with the help of a better government organization in Chicago we put a sign in a storefront and said that professional inquiries would be invited. The inquiries came, all right; but many were offers of kickbacks, some of which were made on camera by "60 Minutes" photographers. An estimated one out of five dollars spent by Medicaid in Illinois, it was asserted in our report, goes for such kickback schemes.

-- And then, last August, we called another hearing in which our investigators -- including Senator Frank Moss -- testified as to the shocking findings from their visits to so-called Medicaid mills. You may remember some of the testimony: The "ping-ponging" from one unneeded treatment to the other, the man who complained of a cold and received arch supports, the unneeded electrocardiograms and several X-rays apparently made without film. And the terrible irony -- the prescribing of medications not really needed -- while nearby in the very neighborhoods in which large concentrations of low-income elderly live, many older persons had to make the daily choice between food and prescription drugs because Medicare does not now cover those drugs, except during hospitalization.

I've given you just a few of the highlights of our inquiries into fraud and abuse, not to depress you, but to make the point which Senator Church made so emphatically a few months ago when he opened a hearing at which two prosecutors gave their recommendations for dealing with such scandals. The Senator, in the company of Senator Moss, assured everyone present that our investigations would continue. He believes that there is much more to be examined, including possible home health ripoffs which were the subject of a hearing earlier this year. But even more fundamentally, he wonders how on earth we can hope for a national health insurance program for all age groups until we take tighter hold of Medicaid and Medicare than we do. And a tighter hold which will do more than merely prevent waste -- a tighter hold which will also assure a higher quality of care. It was significant, I think, that parts of Senator Talmadge's Medicare and Medicaid fraud bill were enacted soon after our hearing. It is also significant that the parts which were not passed are moving satisfactorily to enactment. And it is very significant that Jimmy Carter, before and after he became President, promised an early crack down on waste and stealing in the nation's health programs.

But if waste and stealing is what we don't want, what is it exactly that we do want?

THE ESSENTIAL COMMUNITY OPTIONS

Some of you may know that the Committee on Aging gave early attention to home health services as a much-needed resource in need of development and in need of more reasonable Medicare reimbursement policies. Two reports issued fairly soon after the 1971 White House Conference, charted a course for future action, and served as a manual to help individual programs get started.

But the author of those two papers, Brahna Trager of California, wrote another report for us last year, one dealing with Adult Day Facilities and the Elderly. She devoted one part of that excellent report to home health and said that it was a case of very little progress. Medicare payments for home health are still less than one-half of all Medicare expenditures. Senator Church was successful almost two years ago in winning enactment of a modest bill to encourage development of home health agencies, but H.E.W. was so slow in implementing it that he had to introduce legislation to extend the program last year. And then there is the question of multiple reimbursement. Home health gets a small share of the Medicare money, a larger share of Medicaid's (and in some States, Medicaid reimburses proprietary home health agencies) and more and more through the Title XX Social Service Programs which in many States may not have even the fairly loose Medicaid standards. The results involve more than fantastic paperwork requirements; they also involve a new opportunity for highly questionable practices which can yield high profits and poor care. And what is being done within H.E.W to cut through the present confusion and arrive at reasonable standards of performance and reimbursement? This is a matter we will soon explore in still another hearing and paper, and I am afraid that the conclusion will be that nobody at H.E.W. is in charge of what we have come to call "alternatives to long-term care". But there is also good reason to believe that much of the information obtained is not being used either because it is flawed by poor research procedures, or simply because nobody at H.E.W. is very interested.

Home health care, of course, is not a cure-all for chronic illness or health maintenance problems of older Americans. We need other so-called "alternatives to institutionalization". I say "so-called" because I believe that -- as many others have pointed out -- that the "alternatives" psychology leads to an artificial division of the real possibilities. Brahna Trager asks instead for what she calls "essential community options" in which care programs precisely tailored to meet the individual human needs of individual human beings can be fashioned with skill, compassion, and good effect.

I do not know precisely how to achieve this. Perhaps even Brahna Trager does not. But she -- and many others who are devoting research and thought to the subject -- are helping us to see the directions that should be taken. And we can take steps in the right directions if we know what we really want. We can improve Medicare -- and stop the drift toward higher and higher costs and lower and lower benefits -- if we insist upon transforming it, as Robert Butler says, from an illness program to a health care program which intelligently meets the real needs of the people it is meant to serve.

We can look to an Older Americans Act which -- if it gives area agencies on aging the flexibility and the funding they need to build up from the community level with the active understanding and support of state agencies -- an important role in tying health and social services into serviceable packages which strike elderly persons as sensible and acceptable.

We can insist that housing programs -- including direct loan 202 and public housing -- include services for their aging tenancy as well as mere shelter. And we can look more deeply into community block grants to direct them more certainly to that goal -- housing with needed services -- as well. And we should certainly insist that community mental health centers should do more for the elderly, even while we recognize that emotional stability can be affected for the better by, for example, a senior center which really opens new sides of personality which even they did not know about, or for another example, a job opportunity -- part time or otherwise which convinces that they can after all, still earn money for a job well done.

CONCLUSION

It seems to me that something very exciting is happening in this country.

I think that more and more, in varying ways within varying communities, older persons are taking hold of the retirement existences -- so often upon them against their will -- and insisting that those existences be satisfying as well as secure.

I think that this insistence upon satisfaction is so powerful that it has survived -- it has even flourished -- despite an essentially negative attitude within the Executive Branch over the past 8 years in terms of appropriations requested -- or not requested at all -- or barriers put in the way of promising programs.

What is happening is bigger than federal funding sources, and I quickly add that such funding is needed and will be needed to make things happen faster and more certainly. What is happening is, to use a phrase borrowed from a recent inaugural address -- a new spirit -- a new spirit about aging which is being expressed with growing force and often inspiring results.

We have hard work yet to do, but let's remember the inspiration as well. It will make the work all the easier to get done, now and in the future. And it will one day produce more light than shadows, for each one of us to enjoy and each one of us to take pride in, no matter what our ages -- because what we now do together for Older Americans will benefit future generations, as well.

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